STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Irvine Neuro Rehabilitation
Petitioner **File No. 21-1864**

v

Auto Club Insurance Association
Respondent

Issued and entered
this 17th day of February 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 15, 2021, Irvine Neuro Rehabilitation (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Auto Club Insurance Association (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on December 6, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the date of service at issue.

The Department accepted the request for an appeal on January 3, 2022. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on January 3, 2022 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on January 11, 2022.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on January 26, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on November 15, 2021. The Current Procedural Terminology (CPT) codes at issue include 97112 and 97116, which are described as neuromuscular re-education and gait training. In its *Explanation of Benefits* letter, the Respondent stated that the treatment "exceeds the period of care for either utilization or relatedness" and referenced Official Disability Guidelines (ODG) for physical therapy of the hip and pelvis conditions in support. The Respondent further noted that the medical documentation did not support payment for the treatment at issue.

With its appeal request, the Petitioner identified the injured person's diagnoses as diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration and sequela, traumatic arthropathy of the left hip, presence of left artificial hip joint and unequal limb length. The Petitioner noted that the injured person was involved in a motor vehicle accident in February of 1993.

The Petitioner's request for an appeal stated:

> The complexity of [the injured person's] neurologic and orthopedic injuries require ongoing skilled therapy to address deficits with balance, gait, strength, neuromuscular and cognitive function. [The injured person's] severe safety limitations due to multiple and complex injury-related deficits establish a vital need for skilled therapeutic services to reduce the risk of additional functional decline leading to increased burden of medical care.

In its reply, the Respondent reaffirmed its position and referenced the American College of Occupational and Environmental Medicine (ACOEM) guidelines for traumatic brain injury as well as ODG guidelines. The Respondent stated in its reply:

> The medical records do not support this request, as the guidelines have exceeded the ACOEM recommendations, per documentation physical therapy has been ongoing for well over 50 visits…Additional visits exceed ACOEM and Official Disability Guidelines treatment guideline recommendations. Subjective reports: "little to no pain," and "ambulating with rolling walker and corrective shoe lift" were noted. The quantity of sessions completed to date exceeds the ACOEM and Official Disability Guideline treatment recommendations with ample opportunity given to establish a home exercise program.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that

the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding inappropriate treatment and overutilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the date of service at issue and the treatment was overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is a licensed doctor of physical therapy. In its report, the IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, board, and associations. The IRO reviewer relied on ACOEM guidelines for post-operative exercise and rehabilitation program for hip fracture patients as well as ODG for Auto Injury guidelines for its recommendation.

The IRO reviewer explained that ACOEM guidelines recommend therapy 2 or 3 times per week in outpatient settings "gradually tapered as home exercises are instituted." In addition, the IRO reviewer explained that ODG recommends 24 visits of physical therapy over a range of 10 weeks. The IRO reviewer noted that the injured person attended 55 sessions of physical therapy and that "this exceeds standard of care recommendations in quantity as well as elapsed time."

The IRO reviewer opined:

> While exceptions can be made for some additional treatment when comorbidities are a factor, there is no documentation of such health problems that would preclude the [injured person] from being transitioned to a home-care program. Furthermore, it is noted that original evaluation was documented to have been 03/17/2021 and there were no documents submitted to establish if formal re-evaluations have taken place.

The IRO reviewer recommended that the Director uphold the Respondent's determination that the physical therapy treatments provided to the injured person on November 15, 2021 were not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determination dated December 6, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford